STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
POC #2	445373	A. BUILDING _____ B. WING _____	01/08/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHSIDE HEALTH CARE NURSING AND REHABILITATION C	202 EAST MTCS ROAD MURFREESBORO, TN 37130

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey was completed on 1/8/2020 at Northside Healthcare Nursing and Rehabilitation Center. Deficiencies were cited related to the recertification survey under 42 CFR PART 483, Requirements for Long Term Care Facilities which resulted in Immediate Jeopardy (IJ) (a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause serious injury, harm, impairment or death to a resident). The facility's failure to implement appropriate interventions and to eliminate a foreseeable and known accident hazard in the resident's environment placed 1 (#13) of 4 residents reviewed for falls in Immediate Jeopardy. The Administrator was informed of the Immediate Jeopardy (IJ) on 1/8/2020 at 1:05 PM in her office. F-656 and F-689 were cited at a scope and severity of "J." The facility was cited F-689 at a scope and severity of "J" which is Substandard Quality of Care. An extended survey was conducted from 1/8/2020. The Immediate Jeopardy was effective on 1/8/2020. An Immediate Action Removal Plan which removed the immediacy of the jeopardy was received on 1/8/2020 at 8:10 PM and corrective	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jeanette DeFazio | TITLE: Administrator | (X6) DATE: 1/31/2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

RECEIVED
2-7-2020

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F 000	Continued From page 1 actions were validated on site by the surveyors on 1/8/2020. The facility's noncompliance at F-656 and F-689 continues at a scope and severity of "D" for the monitoring of the effectiveness of the corrective actions. The facility is required to submit a Plan of Correction.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her	F 550	F550 1. Corrective action(s) accomplished for those residents found to have been affected by the alleged deficient practice: A. Resident #104's catheter bag was immediately covered with a privacy bag on 1/6/2020 by Staffing Coordinator. 2. Identify other residents who have the potential to be affected by the same alleged deficient practice and what corrective action taken: A. All residents with Foley catheters have the potential to be affected by this alleged deficient practice. B. A 100% audit by the Risk Manager was conducted on 1/6/2020 to ensure all catheter bags were covered with a privacy bag.	

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F 550	Continued From page 2 rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on facility policy review, medical record review, observation and interview, the facility failed to ensure dignity for 1 (#104) of 4 residents reviewed with catheters when the facility failed to ensure the resident's indwelling urinary catheter drainage bag was covered. The findings include: Facility policy review, Promoting/Maintaining Resident Dignity, revised 11/2017 revealed "...It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances the resident's quality of life by recognizing each resident's individuality..." Medical record review revealed Resident #104 was admitted to the facility on 1/3/2020 with diagnoses which included Neuromuscular Dysfunction of Bladder, Wedge Compression Fracture of T5 and T6 Vertebrae (bones in the	F 550	3. Measure/systematic changes put in place to ensure that the deficient practice does not reoccur: A. Licensed nurses and certified nursing assistants were in-serviced by the Director of Nursing on 1/6/2020 in regard to maintaining dignity of the resident. 4. Monitoring of corrective action to ensure the deficient practice will not reoccur: A. Risk Manager will conduct a daily audit for one-week, weekly audit for 3 weeks, then a monthly audit for 3 months. to ensure privacy bags are in place. She then will conduct a monthly audit for 3 months to ensure privacy bags are in place and report findings to the QAPI committee. B. Audit will be reviewed by Risk Manager at monthly QAA meetings for tracking and trends. Completion Date 2/22/2020	2/22/2020

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F 550	Continued From page 3 spine) and Paraplegia. Medical record review of Resident #104's Physician Orders dated 1/3/2020 revealed "...maintain indwelling catheter two times a day..." Observation on 1/6/2020 at 10:14 AM, 12:30 PM, 1:40 PM, 2:40 PM and 2:50 PM in Resident #104's room revealed the catheter drainage bag visible on the right side of the bed and not covered. Interview with the Licensed Practical Nurse #1 on 1/6/2020 at 2:50 PM in Resident #104's room confirmed the catheter drainage bag was not covered. Interview with the Director of Nursing on 1/7/2020 at 2:40 PM in her office confirmed catheter drainage bags "should always be in a privacy bag."	F 550	F641 1. Corrective action(s) accomplished for those residents found to have been affected by the alleged deficient practice: A. Resident #33's MDS Assessment was updated on 1/8/2020 by MDS Coordinator. B. An in-service was conducted on 1/9/20 by the Administrator with the MDS coordinator regarding the completion of MDS assessments and documentation. 2. Identify other residents who have the potential to be affected by the same alleged deficient practice and what corrective action taken: A. All residents with fall occurrences have the potential to be affected by this alleged deficient practice. B. An audit of residents with falls within the last quarter was initiated on 1/31/2020 by the Administrator and DON with a 100% completion to be achieved by 2/7/2020.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview the facility failed to accurately assess 1 (#33) of 4 residents reviewed for falls on the Minimum Data Set (MDS). The Findings include: Medical record review revealed Resident #33 was admitted to the facility on 1/28/2019 with	F 641		

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F 641	Continued From page 4 diagnoses which included Cancer, End Stage Renal Disease, Type 2 Diabetes with Neuropathy and Chronic Respiratory Failure. Medical record review of Resident #33's Interdisciplinary Team Occurrence Investigation Worksheet dated 9/1/2019 revealed "...Patient was observed on the floor related to brakes on wheelchair not locked and wheelchair rolled backwards..." Medical record review of Resident #33's Quarterly MDS dated 10/24/2019 revealed no falls. Interview with the MDS Coordinator on 1/8/2020 at 6:33 PM in her office confirmed the 9/1/2019 fall for Resident #33 was not captured on the Quarterly MDS dated 10/24/2019.	F 641	3.Measure/systematic changes put in place to ensure that the deficient practice does not reoccur: A. MDS Coordinator was in-serviced by Administrator on 1/9/2020 regarding completion of MDS assessments and proper documentation. 4. Monitoring of corrective action to ensure the deficient practice will not reoccur: A. MDS Coordinator will submit a signed completed assessment list to Administrator of all falls being documented on Quarterly Assessments. B. Administrator will conduct audits of quarterly assessments daily for one week, weekly for 3 weeks and then monthly for 3 months and report findings to the QAPI committee. C. Audit will be reviewed by Administrator monthly at QAA meetings for tracking and trends. Completion Date: 2/22/2020	2/22/2020
F 656 SS=J	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not	F 656	F656 1. Corrective action(s) accomplished for those residents found to have been affected by the alleged deficient practice: A. On 1/8/2020, additional padding was added to the overbed table for Resident #13 by the Maintenance Supervisor.	

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F 656	Continued From page 5 provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on facility policy review, medical record review, facility investigation, observation and interview, the facility failed to implement care plan interventions for 1 (#13) of 4 residents reviewed for falls. The facility's noncompliance placed Resident #13 in Immediate Jeopardy (IJ) (a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause serious injury, harm, impairement or death to a resident). The Administrator was informed of the Immediate Jeopardy (IJ) on 1/8/2020 at 1:05 PM in her office.	F 656	B. The care plan and fall interventions for Resident #13 were reviewed and updated by the Risk Manager on 1/8/2020 to ensure proper placement to assist with reducing the risk for further accidents and/or injuries. 2. Identify other residents who have the potential to be affected by the same alleged deficient practice and what corrective action taken: A. All residents have been identified as having the potential to be affected. B. 100% audit of care planned interventions was conducted on facility residents by the Administrator, Director of Nursing, Regional Nurses, Staffing Coordinator and Risk Manager on 1/8/2020 to ensure the care planned interventions were implemented. 3. Measure/systematic changes put in place to ensure that the deficient practice does not reoccur: A. Interdisciplinary care plan team was educated on 1/8/2020 by the Regional Nurse Manager regarding monitoring of safety hazards, implementation of appropriate interventions, and the facility's process for auditing safety interventions. B. The Nurse Managers to include the Director of Nursing, Assistant Director of Nursing, Staffing Coordinator, Unit Manager, Admissions Coordinator, and	

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F 656	Continued From page 6 F-656 was cited at a scope and severity of "J." An extended survey was conducted on 1/8/2020. The Immediate Jeopardy was effective on 1/8/2020. An Immediate Action Removal Plan which removed the immediacy of the jeopardy was received on 1/8/2020 at 8:10 PM and corrective actions were validated on site by the surveyors on 1/8/2020. The facility's noncompliance at F-656 continues at a scope and severity of "D" for the monitoring of the effectiveness of the corrective actions. The facility is required to submit a Plan of Correction. The findings include: Facility policy review, Comprehensive Care Plans, dated 11/2016 and revised 2/2019, revealed "...Develop and implement a comprehensive person-centered care plan for each resident that includes measurable objectives and time frames to meet a resident's medical, nursing and psychosocial needs...staff are responsible for carrying out interventions specified in the care plan..." Facility policy review, Accidents and Supervision, dated 11/2017, revealed "...The resident environment remains as free of accident hazards as is possible...This includes...Implementing interventions to reduce hazard(s) and risk(s)...modifying interventions when	F 656	Risk Manager were educated by the Administrator on 1/8/2020 regarding the implementation/maintenance of interventions for identified hazards. C. Education was initiated to licensed nursing and certified nursing assistants by the Assistant Director of Nursing on 1/8/2020 regarding the implementation/maintenance of interventions for identified hazards and were instructed to notify their supervisor immediately if interventions were not properly placed. D. Prior to returning to work off duty licensed nurses and certified nursing assistants will be educated by the Nurse Managers to include the Director of Nursing, Assistant Director of Nursing, Staffing Coordinator, Unit Manager and Risk Manager on ensuring the implementation/maintenance of interventions for identified hazards and to notify their supervisor immediately if interventions are not in place. As of 1/8/2020 62% of licensed nurses and certified nursing assistants have been educated. This education will be completed by 1/15/2020. E. On 1/8/2020 a new step to the fall, accident, and injury process was added by the DON to the resource materials which included monitoring of the treatment administrator record for current safety interventions. F. Safety interventions were added to the treatment administration record by the ADON by 1/10/2020.	

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F 656	Continued From page 7 necessary...Implementation of Interventions include: Communicating the interventions to all relevant staff...Ensuring that the interventions are put into action..." Medical record review revealed Resident #13 was admitted to the facility on 4/7/2016 with diagnoses which included Hemiplegia Affecting Right Dominant Side, Dementia With Behavioral Disturbance, Aphasia, Low Vision To Right Eye and Peripheral Vascular Disease. Medical record review of Resident #13's Quarterly Minimum Data Set (MDS) dated 1/3/2019 revealed Brief Interview for Mental Status (BIMS) score of 6 which indicated severe cognitive impairment. Continued review revealed Resident #13 required extensive assistance with 1 person assist for bed mobility, dressing, and personal hygiene; limited assistance with 1 person for transfer and toilet use; total dependence with support for bathing. Continued review revealed the resident was not steady and only able to stabilize with staff assistance; moving from seated to standing position, moving on and off toilet and surface to surface transfer. Further review revealed Resident #13 had a fall within 30 days prior to admission to the facility. Medical record review of Resident #13's Interdisciplinary Team Occurrence Investigation Worksheet, dated 1/14/2019 revealed Resident #13 had an unwitnessed fall with head laceration on 1/14/2019 and he was sent to emergency room for sutures. Continued review revealed the resident was attempting to use his urinal when he slid from his chair and hit his head on the base of the bedside (overbed) table. Further review revealed the interventions to be put into place	F 656	4. Monitoring of corrective action to ensure the deficient practice will not reoccur: A. The Risk Manager and/or supervising nurse will monitor that the appropriate interventions have been implemented and are recorded in the treatment administration record within 24 hours of a fall, injury and/or accident. B. All newly hired licensed nurses and certified nursing assistants will be educated by the Staffing Coordinator during orientation on implementation and maintenance of interventions for identified hazards and what to do if interventions are not properly placed. C. The Nurse Managers to include the Director of Nursing, Assistant Director of Nursing, Staffing Coordinator, Unit Manager and Risk Manager will audit new interventions implemented for identified hazards daily for one week, weekly for three weeks, then monthly for three months. The findings of the audit will be reported to the QAPI Committee which consists of the Administrator, Director of Nursing, Assistant Director of Nursing, MDS Coordinator, Social Services Director, Maintenance Supervisor, Activities, Certified Dietary Manager, Admissions Coordinator, Risk Manager, Staffing Coordinator and Medical Director. If compliance is not met. Audits will be continued weekly until compliance is met. Completion Date: 2/22/2020	2/22/2020

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F 656	Continued From page 8 were to pad the base of the bedside [overbed] table. Medical record review of Resident #13's Emergency Department record, dated 1/14/2019, revealed "...Laceration 4 centimeters [cm] in length. Scalp...5 staples...Bleeding controlled...closed head injury...scalp lac [laceration]..." Medical record review of Resident #13's Care Plan dated 1/14/19 revealed "...Pad base of bedside[overbed] table r/t Fall 1/14/2019..." Medical record review of Resident #13's Resident Care Summary Assessment dated 11/19/2019 and 1/7/2020 revealed "...Pad base of bedside [overbed] table..." Observation on 1/8/2020 at 10:08 AM in Resident #13's room revealed 2 metal legs and supporting metal bar were not padded on the bedside [overbed] table base. Observation and interview with the Director of Nursing in Resident #13's room on 1/8/2020 at 10:12 AM confirmed fall interventions were not implemented as care planned for Resident #13. Interview with Licensed Practical Nurse (LPN) #3 in the dining room on 1/8/2020 at 1:30 PM confirmed Resident #13 was a high falls risk and she was unaware the bedside [overbed] table base was supposed to be padded. The surveyors verified the Immediate Action Removal Plan by: 1. The surveyors verified Resident #13's bedside	F 656		

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F 656	Continued From page 9 [overbed] table base had been padded to prevent any further accidents and hazards as care planned. The Surveyors then verified a new process included placing the order for safety interventions on the Physician's Order Sheet and the monitoring of the interventions on the Treatment Administration Record for Resident #13. 2. The surveyors reviewed and verified the safety interventions were in place for Resident #13. Continued review verified the facility's 100% audit of all 47 resident care plans to ensure interventions to prevent accidents and hazards had been implemented. 3. The surveyors reviewed and verified the education and training for the Nurse Managers to include Director of Nursing, Assistant Director of Nursing, Staffing Coordinator, Unit Manager, Admissions Coordinator and Risk Management by the Administrator regarding the implementation/maintenance of interventions for identified hazards. The surveyors verified the education and training of licensed nurses and certified nursing assistants by the Assistant Director of Nursing regarding the implementation/maintenance of interventions for identified hazards and were instructed to notify their supervisor immediately if interventions were not in place. The surveyors verified the facility's Quality Assurance Process Improvement (QAPI) meeting held on 1/8/2020 to include discussion related to updating and following care plan interventions.	F 656		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689	F689 1. Corrective action(s) accomplished for those residents found to have been affected by the alleged deficient practice: A. On 1/8/2020, additional padding was added to the overbed table for Resident #13 by the Maintenance Supervisor.	

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NORTHSIDE HEALTH CARE NURSING AND REHABILITATION C	202 EAST MTCS ROAD MURFREESBORO, TN 37130

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F 689	Continued From page 10 §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on facility policy review, medical record review, facility investigation, observation and interview, the facility failed to eliminate a foreseeable and known accident hazard in the resident's environment for 1 (#13) of 4 residents who were assessed at risk for falls. The facility's noncompliance placed Resident #13 in Immediate Jeopardy (IJ) (a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause serious injury, harm, impairement or death to a resident).. The Administrator was informed of the Immediate Jeopardy (IJ) on 1/8/2020 at 1:05 PM in her office. F-689 was cited at a scope and severity of "J" which was Substandard Quality of Care. An extended survey was conducted on 1/8/2020. The Immediate Jeopardy was effective on 1/8/2020. An acceptable Immediate Action Removal Plan which removed the immediacy of the jeopardy was received on 1/8/2020 at 8:10 PM and corrective actions were validated on site by the	F 689	B. The care plan and fall interventions for Resident #13 were reviewed by the Risk Manager on 1/8/2020 to ensure they were in place to help reduce the risk for further accidents and/or injuries. 2. Identify other residents who have the potential to be affected by the same alleged deficient practice and what corrective action taken: A. All residents have been identified as having the potential to be affected. B. 100% audit of care planned interventions was conducted on facility residents by the Administrator, Director of Nursing, Regional Nurses, Staffing Coordinator and Risk Manager on 1/8/2020 to ensure the care planned interventions were implemented. 3. Measure/systematic changes put in place to ensure that the deficient practice does not reoccur: A. Interdisciplinary care plan team was educated on 1/8/2020 by the Regional Nurse Manager regarding monitoring of safety hazards, implementation of appropriate interventions, and the facility's process for auditing safety interventions. B. The Nurse Managers to include the Director of Nursing, Assistant Director of Nursing, Staffing Coordinator, Unit Manager, Admissions Coordinator, and Risk Manager were educated by the Administrator on 1/8/2020 regarding the implementation/maintenance of interventions for identified hazards.	

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	445373	A. BUILDING _____ B. WING _____	01/08/2020

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NORTHSIDE HEALTH CARE NURSING AND REHABILITATION C	202 EAST MTCS ROAD MURFREESBORO, TN 37130

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F 689	Continued From page 11 surveyors on 1/8/2020. The facility's noncompliance at F-689 continues at a scope and severity of "D" for the monitoring of the effectiveness of the corrective actions. The facility is required to submit a Plan of Correction. The findings include: Facility policy review, Accidents and Supervision, dated 11/2017, revealed "...The resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistive devices to prevent accidents. This includes: Identification of Hazards and Risk...Evaluating and analyzing hazard(s) and risk(s)...Implementing interventions to reduce hazard(s) and risk(s)...Monitoring for effectiveness and modifying interventions when necessary...All staff are to be involved in observing and identifying potential hazards in environment...Implementation of Interventions include: Communicating the interventions to all relevant staff...Assigning responsibility...Providing training as needed...Ensuring that the interventions are put into action..." Medical record review revealed Resident #13 was admitted to the facility on 4/7/2016 with diagnoses which included Hemiplegia Affecting Right Dominant Side, Dementia With Behavioral Disturbance, Aphasia, Low Vision To Right Eye and Peripheral Vascular Disease. Medical record review of Residents #13's Quarterly Minimum Data Set (MDS) dated 8/30/2019 revealed a Brief Interview of Mental	F 689	C. Education was initiated to licensed nursing and certified nursing assistants by the Assistant Director of Nursing on 1/8/2020 regarding the implementation/maintenance of interventions for identified hazards and were instructed to notify their supervisor immediately if interventions were not in place. D. Prior to returning to work off duty licensed nurses and certified nursing assistants will be educated by the Nurse Managers to include the Director of Nursing, Assistant Director of Nursing, Staffing Coordinator, Unit Manager and Risk Manager on ensuring the implementation/maintenance of interventions for identified hazards and to notify their supervisor immediately if interventions are not in place. As of 1/8/2020 62% of licensed nurses and certified nursing assistants have been educated. This education was completed by 1/15/2020. E. On 1/8/2020 a new step to the fall, accident, and injury process was added to the resource materials which included monitoring of the treatment administrator record for current safety interventions. F. F. Safety interventions were added to the treatment administration record by the ADON by 1/10/2020.	

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F 689	Continued From page 12 Status (BIMS) score of 3 which indicated severe cognitive impairment. Continued review revealed Resident #13 required extensive assistance with 1 person for bed mobility, transfer and toilet use. Continued review revealed the Resident was only able to stabilize with staff assistance for all transfers. Medical record review of Resident #13's Interdisciplinary Team Occurrence Investigation Worksheet, dated 1/14/2019 revealed an unwitnessed fall with head laceration on 1/14/2019 and the resident was sent to the emergency room for sutures. Continued review revealed the resident was attempting to use a urinal when he slid from the chair and hit his head on the base of the bedside [overbed] table. Further review revealed facility interventions put into place was to pad the base of the resident's bedside (overbed) table. Medical record review of Resident #13's Emergency Department record, dated 1/14/2019, revealed "...Laceration 4 centimeters [cm] in length. Scalp...5 staples...Bleeding controlled...closed head injury...scalp lac [laceration]..." Medical record review of Resident #13's Care Plan dated 4/9/2019- Present, revealed "...at risk for bleeding r/t [related to] use of anticoagulant [blood thinning medication]...Implement safety precautions such as fall management protocols...At risk for falls r/t decreased mobility...Pad base of bedside [overbed] table r/t Fall 1/14/2019..." Medical record review of Resident #13's Physician Order Sheet dated January 2019	F 689	4. Monitoring of corrective action to ensure the deficient practice will not reoccur: A. The Risk Manager and/or supervising nurse will monitor that the appropriate interventions have been implemented and is recorded in the treatment administration record within 24 hours of a fall, injury and/or accident. B. All newly hired licensed nurses and certified nursing assistants will be educated by the Staffing Coordinator during orientation on implementation and maintenance of interventions for identified hazards and what to do if interventions are not properly placed. C. The Nurse Managers to include the Director of Nursing, Assistant Director of Nursing, Staffing Coordinator, Unit Manager and Risk Manager will audit new interventions implemented for identified hazards daily for one week, weekly for three weeks, then monthly for three months. The findings of the audit will be reported to the QAPI Committee which consists of the Administrator, Director of Nursing, Assistant Director of Nursing, MDS Coordinator, Social Services Director, Maintenance Supervisor, Activities, Certified Dietary Manager, Admissions Coordinator, Risk Manager, Staffing Coordinator and Medical Director. If compliance is not met. Audits will be continued weekly until compliance is met. Completion Date: 2/22/2020	2/22/2020

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F 689	Continued From page 13 revealed Xarelto [blood thinner] 20 mg [milligram] tablet give one tablet by mouth at bedtime. Medical record review of Resident #13's Physician Order Sheet dated October 2019 and December 2019 revealed Xarelto was changed to Eliquis. Continued review of the Physician Order revealed "...Eliquis [blood thinner] 5 mg tablet po [by mouth] BID [twice a day]..." Continued review of the Physician Order revealed...Fall precautions..." Medical record review of Resident #13's Resident Care Summary Assessment dated 11/19/2019 and 1/7/2020 revealed "...Pad base of bedside table [overbed table]..." Observation on 1/8/2020 at 10:08 AM in Resident #13's room revealed 2 metal legs and supporting bar were not padded on the base of the bedside (overbed) table base. Observation and Interview on 1/8/2020 at 10:12 AM with Director of Nursing present in Resident #13's room confirmed the facility was aware of Resident #13's fall risk and after looking at the base of the bedside [overbed] table, she said "there is still the potential for injury for the resident due to the base of the bedside [overbed] table not being padded." Interview with Certified Nurse Assistant (CNA) #1 in the dining room on 1/8/2020 at 1:15 PM confirmed he had been in Resident #13's room the morning of 1/8/2020 and he stated "I was not aware [named resident] bedside table [overbed] base was supposed to be padded until I noticed [named staff] Maintenance Supervisor was putting padding on the bedside [overbed] table	F 689		

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F 689	Continued From page 14 base." The surveyors verified the Immediate Action Removal Plan by: 1. The surveyors verified on 1/8/2020 Resident #13's room was free of environmental hazards related to padding of the metal base of the bedside [overbed] table removing the foreseeable and known accident hazard. 2. The surveyors reviewed and verified the safety interventions were in place for Resident #13. Continued review verified the facility's 100% audit of all 47 resident care plans to ensure interventions to prevent accidents and hazards had been implemented. 3. The surveyors reviewed and verified the education and training for the Nurse Managers, licensed nurses and certified nursing assistants regarding the implementation/maintenance of interventions for identified hazards had been initiated. The surveyors verified the education and training of licensed nurses and certified nursing assistants regarding instructions to notify their supervisor immediately if interventions were not in place had been initiated. The surveyors verified the facility's Quality Assurance Process Improvement (QAPI) meeting was held on 1/8/2020 to include discussion related to incidents/accidents.	F 689		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812	F812 1. Corrective action(s) accomplished for those residents found to have been affected by the alleged deficient practice: A. Resident #6's food was immediately returned to the kitchen by the CNA and a new plate of food was given to resident #6. B. Certified nursing assistants were In-serviced on 1/6/2020 about the	

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F 812	Continued From page 15 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on facility policy review, medical record review, observation, and interview the facility failed to handle food in a sanitary manner for 1 (#6) of 5 residents observed being served during the noon meal on 1/6/2020 on the 200 hall. The facility's noncompliance placed the resident at an increased risk for transmittable disease. The findings include: Facility policy review, Dietary: Food Safety Requirements, dated 9/2019, revealed "...Food will also be stored, prepared and served in accordance with professional standards for food service safety..." Medical record review revealed Resident #6 was admitted to the facility on 9/27/2018 with diagnoses which included Hemiplegia, Muscle Weakness and Lack of Coordination.	F 812	facility's policy regarding proper food handling. 2. Identify other residents who have the potential to be affected by the same alleged deficient practice and what corrective action taken: A. All residents have the potential to be affected by this alleged deficient practice. B. Certified nursing assistants were In-serviced on 1/6/2020 about the facility's policy regarding proper food handling. 3. Measure/systematic changes put in place to ensure that the deficient practice does not reoccur: A. Certified Nursing Assistants were in-serviced by the Director of Nursing on 1/6/20202 about the facility's policy regarding proper food handling. 4. Monitoring of corrective action will be completed by the Staffing Coordinator to ensure the deficient practice will not reoccur: A. Audits will be conducted during meal times by the Staffing Coordinator to ensure staff are following the proper food handling policy. These audits will be conducted 3x a week for 6 weeks and random audits will continue thereafter to ensure compliance. B. Audits will be reviewed by the Staffing Coordinator monthly at QAA meetings for tracking and trends. Completion Date: 2/22/2020	2/22/2020

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F 812	Continued From page 16 Medical record review of Resident #6's comprehensive care plan dated 9/10/2019 revealed the resident required cues and assistance with meals. Medical record review of Resident #6's Quarterly Minimum Data Set dated 12/10/2019 revealed the resident required supervision with one staff and physical assist for eating. Observation on 1/6/2020 at 11:45 AM in Resident #6's room revealed Certified Nursing Assistant (CNA) #1 moved the resident's grilled cheese sandwich with his right bare hand while assisting the resident with lunch. Interview with CNA #1 outside Resident #6's room on 1/6/2020 at 11:46 AM confirmed he touched the resident's grilled cheese with his bare hand. Interview with the Director of Nursing in front of the nursing station on 1/6/2020 at 2:05 PM confirmed staff were to use gloves when touching residents' food.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program.	F 880	F880 1. Corrective action(s) accomplished for those residents found to have been affected by the alleged deficient practice: A. Resident #104's catheter tubing was immediately removed from the floor on 1/6/2020 by the charge nurse. 2. Identify other residents who have the potential to be affected by the same alleged deficient practice and what corrective action taken:	

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F 880	Continued From page 17 The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and	F 880	A. All residents with Foley catheters have the potential to be affected by this alleged deficient practice. B. A 100% audit by the Risk Manager was conducted on 1/6/2020 to ensure all catheter tubing was not touching the floor and infection control was being maintained. 3. Measure/systematic changes put in place to ensure that the deficient practice does not reoccur: A. Licensed nurses and certified nursing assistants were in-serviced by the Director of Nursing on 1/6/2020 in rearwards to infection control specific to catheter tubing touching the floor. 4. Monitoring of corrective action to ensure the deficient practice will not reoccur: A. Risk Manager will conduct a daily audit for one-week, weekly audit for 3 weeks, then a monthly audit for 3 months. to ensure privacy bags are in place. She then will conduct a monthly audit for 3 months to ensure privacy bags are in place and report findings to the QAPI committee. B. Audits will be reviewed by Risk Manager monthly at QAA meetings for tracking and trends. Completion Date: 2/29/2020	2/29/2020

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F 880	Continued From page 18 (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on facility policy review, medical record review, observation and interview, the facility failed to exercise current standards of practice to prevent the development and transmission of infection for 1 (#104) of 4 residents reviewed with indwelling urinary catheters related to Resident #104's catheter tubing lying on the floor. The facility's noncompliance placed the resident at risk for transmigration of bacteria from the floor into the resident's bladder. The findings include: Facility policy review, Foley Catheter, revised 11/2016 revealed "...Indwelling urinary catheters will be utilized in accordance with current standards of practice, with interventions to prevent complications to the extent possible..." Medical record review revealed Resident #104 was admitted to the facility on 1/3/2020 with diagnoses which included Neuromuscular	F 880		

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F 880	Continued From page 19 Dysfunction of Bladder, Wedge Compression Fracture of T5 (Thoracic vertebra) through T6 vertebra (bones in the spine) and Paraplegia. Medical record review of Resident #104's Physician Orders dated 1/3/2020 revealed "...maintain indwelling catheter two times a day..." Observation on 1/6/2020 at 2:40 PM and 2:50 PM in Resident #104's room revealed the resident's catheter drainage tubing was connected to the resident and the catheter drainage tubing was lying on the floor under the bed. Observation and Interview with Licensed Practical Nurse (LPN) #1 on 1/6/2020 at 2:50 PM in Resident #104's room confirmed the catheter drainage tubing was connected to the resident and the catheter drainage tubing was lying on the floor under the resident's bed.	F 880		

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E 000	Initial Comments An emergency preparedness survey was completed on 1/8/2020 at Northside Health Care and Rehabilitation Center. No deficiencies were cited under FED-E-1.00.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Annette Dixon | Administrator | 1/31/2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.